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ABSTRACT

Increasingly, people receiving public-supported health care are seeking help for and/or presenting with both substance abuse and mental disorders. People with these co-occurring disorders often require help from many different care systems. Consequently, no single system of care is adequately prepared to help people with both mental and substance abuse disorders on its own, and many people with co-occurring disorders do not receive the continuum of specialized services they need. This project seeks to identify strategies of developing effective treatment programs for people with co-occurring disorders. A national screening of the mental health and substance abuse fields identified programs in diverse settings that deliver effective treatment for different types of people with co-occurring disorders. Project participants discussed community-based programs and evaluated systemic support at the State, county, and regional levels. Systems-level participants described their strategies to build more comprehensive services. Throughout the process, participants described a wide range of clinical, financial, programmatic, and training barriers to delivering treatment and building systems of care. However, none of these obstacles are insurmountable; indeed, with consistency and clarity, participants described how they overcame each one. Their approaches included: using replicable strategies and tools; employing strong leadership at both the provider and systems levels; and involving important stakeholders. Finally, this report outlines a series of recommendations and "next steps." Seven appendixes include a Co-Occurring Disorders by Severity Matrix, findings from expert panels, and training curricula. (GCP)

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Strategies for Developing Treatment Programs

for People With Co-Occurring Substance Abuse and Mental Disorders

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Strategies for Developing Treatment Programs

for People With Co-Occurring Substance Abuse and Mental Disorders

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Disclaimer

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Foreword

Research has confirmed that people with co-occurring substance abuse and mental disorders are a large, significantly underserved population in the United States. They experience multiple health and social problems and require a panoply of services that cut across systems of care, including substance abuse treatment, primary health care, mental health services, and long-term care. People with co-occurring mental and substance abuse disorders also experience a broad range of social service needs; they may be homeless or located within the criminal justice system. Few have substantial resources or supports. No one single care system is sufficiently equipped—in resources, training, and service capacity—to serve individuals with co-occurring substance abuse and mental disorders.

A variety of factors contribute to the inability of individual service systems to provide people with co-occurring disorders the full range of needed and appropriate services, including:

- Separate, uncoordinated mental health and substance abuse treatment providers and service programs
- Disparate health insurance benefits for the treatment of mental illness compared with substance abuse and for the treatment of both compared with other health problems
- An absence of a single locus of responsibility for the treatment of individuals with co-occurring disorders
- Insufficient numbers of cross-trained staff
- Differing treatment philosophies within the mental health and substance abuse communities, coupled with clinician discomfort in working in areas beyond the scope of their specific training
- An insufficient services research base to support evidence-based practices in the treatment of persons with co-occurring disorders
- A dearth of instruments and trained personnel to assess and screen accurately and reliably for co-occurring mental and substance abuse disorders
- Inadequate funding not only for substance abuse treatment and mental health services in general but also for the treatment of co-occurring disorders in particular.

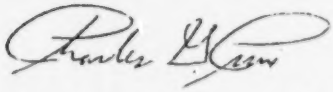
We recognize that, ultimately, service system change must occur at the level of the community-based service provider. To help move toward this changed vision of service delivery, the Substance Abuse and Mental Health Services Administration (SAMHSA) joined with the National Council for Community Behavioral Healthcare (NCCBH) and the State Associations of Addiction Services (SAAS) to identify problems and seek solutions. Specifically, this report— "Strategies for Developing Treatment Programs for People With Co-Occurring Substance Abuse and Mental Disorders"—highlights challenges to service delivery, delineates strategies to overcome these challenges, identifies methodologies to help public purchasers build integrated care systems, and describes core competencies and training from which treating professionals and the people they serve can benefit.

As this initiative began, the field shared the singular assumption that the barriers to providing integrated services for people with co-occurring substance abuse and mental disorders were insurmountable.

The knowledge gleaned from the collaboration among SAMHSA, NCCBH, and SAAS, however, tells a different story. Through special expert panel discussions, investigators identified and brought together individuals who developed and today operate successful programs serving people with co-occurring substance abuse and mental disorders. Moreover, those individuals helped identify how they successfully overcame barriers to service delivery. Project investigators discovered many replicable and often inexpensive and simple strategies and tools

available for people in the mental health and substance abuse treatment fields to use to provide treatment for people with co-occurring substance abuse and mental disorders.

The information in this report often is anecdotal in nature; yet the results, in many instances, have been stunning. It is true that our ability to deliver effective treatment for co-occurring disorders to all populations in all settings remains a formidable challenge; however, this document describes how, with the leadership of administrators, clinicians, and consumers, we can overcome the challenge and turn what was insurmountable into a reality of services for people with co-occurring substance abuse and mental disorders.



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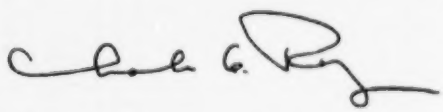

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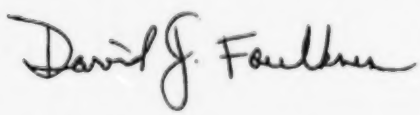

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Executive Summary

Increasingly, people receiving public-supported health care are seeking help for and/or presenting with both substance abuse and mental disorders. People with these co-occurring disorders often require help from many different care systems—not only substance abuse and mental health care services but often primary health care, criminal justice, and social services as well. Consequently, no single system of care is adequately prepared to help people with both mental and substance abuse disorders on its own, and many people with co-occurring disorders do not receive the continuum of specialized services they need.

Both substance abuse and mental health treatment providers recognize the importance of creating programs to treat people with co-occurring disorders. For a variety of reasons, however, they face many challenges in their efforts to fund, staff, and operate such programs.

To help address this situation, the Substance Abuse and Mental Health Services Administration (SAMHSA) commissioned this project in August 2000 to identify strategies of developing effective treatment programs for people with co-occurring disorders. This project is also designed to support SAMHSA's ongoing national training and technical assistance initiatives by identifying:

- Challenges to providing treatment
- Proven strategies and tools that providers use to overcome these challenges
- Strategies and tools that public purchasers use to build integrated care systems
- Core competencies and specific training that treatment staff should acquire.

A national screening of the mental health and substance abuse fields identified programs in diverse settings that deliver effective treatment for different types of people with co-occurring disorders. Leaders of these programs—as well as nationally recognized experts and people who have received treatment for co-occurring disorders—helped provide a great deal of the information in this report by participating in focus groups and telephone interviews.

Participants discussed community-based programs and evaluated systemic support at the State, county, and regional levels. Systems-level participants described their strategies to build more comprehensive services.

Throughout the process, participants described a wide range of clinical, financial, programmatic, and training barriers to delivering treatment and building systems of care. However, none of these obstacles are insurmountable; indeed, with consistency and clarity, participants described how they overcame each one. Their approaches included:

- Using replicable strategies and tools that are often simple and inexpensive
- Employing strong leadership at both the provider and systems levels
- Involving important stakeholders, including consumers and family members.

In this report, the term "systems level" focuses on the public purchaser level. In most cases, the State mental health and substance abuse agencies are responsible for purchasing services and creating systems of care to meet the needs of service recipients. When it comes to implementation, some States delegate authority to county- and/or regional-level bodies. And in some areas, large provider networks serve as another level of purchaser/care coordinator within other divisions (State/county/regional).

Participants acknowledged that provider-level programming (i.e., direct care) is currently more developed than systems-level initiatives. Nevertheless, well-organized and integrated care systems can expand the power of individual treatment programs. They can provide effective pathways for consumers to move between services and can assist consumers in transitioning from active treatment to community-

The authors have included quotes from panel participants in text blocks throughout this report. These quotes reflect the personal perspectives of people engaged in building and sustaining effective programs for individuals with co-occurring disorders.

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based support systems. Thus, as systems of care for people with co-occurring disorders continue to evolve, they will provide support for the advances that treatment providers have made.

An assumption in planning this project was that client variables (e.g., ethnicity and geographic location) create significantly different needs. These differences, however, did not appear as significant as expected. For that matter, neither were provider variables (e.g., mental health/substance abuse settings, hospital-/community-based settings).

Moreover, while obtaining adequate funding is always a challenge to providing a full range of mental health and substance abuse services, participants described how they were able to access and leverage local, State, and Federal funds that provide basic program support. For example, Medicaid—a primary funding source for most public-sector treatment programs—provides greater financial support for mental disorders than for substance abuse disorders. Yet most successful programs and systems of care addressed this challenge by finding ways to supplement Medicaid.

Funding, therefore, is a predictable but not necessarily insurmountable barrier to success. Interestingly, State- and/or county-defined benefit packages and the regulatory environment were identified as more significant variables.

Finally, this report outlines a series of recommendations and "next steps," including:

- Promoting networking among participants and other stakeholders involved in building treatment programs and systems of care for people with co-occurring disorders
- Enabling these same groups to share information and tools more easily
- Increasing program support, especially for transitioning from grants to ongoing funding sources
- Strengthening systems of care at the State, county, and regional levels
- Fostering workforce development strategies
- Creating "roadmap" products that will build on current knowledge for developing treatment programs and systems of care
- Establishing new approaches to funding issues.

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Introduction

Mental health and substance abuse programs have faced the growing challenge of treating people with co-occurring mental and substance abuse disorders for more than 25 years. The current number of people with co-occurring disorders is high, and it is increasing. Conservative estimates suggest that, in any given year, as many as 10 million people in this country have a combination of co-occurring mental and substance abuse disorders, according to the 1994 National Comorbidity Survey. Field reports from member organizations of the National Council for Community Behavioral Healthcare (National Council) and State Associations of Addiction Services (SAAS) indicate that the number is actually significantly higher, and community providers belonging to the California Council of Community Mental Health Agencies reported in 2000 that as much as 80 percent of people seeking treatment presented with some form of co-occurring mental and substance abuse disorders.

Nevertheless, many people with co-occurring disorders receive treatment for only one of their disorders. Even when a person receives treatment for both, it is most often from separate, uncoordinated systems. Therefore, experts widely believe that people with co-occurring disorders are inadequately served in this country—a problem that affects all age groups.

People with co-occurring disorders often experience multiple health and social problems and require treatment that cuts across several systems of care, including substance abuse, mental health, primary health care, and other services. Moreover, many people with co-occurring disorders are homeless and/or connected to the family court, juvenile, or criminal justice system. Yet no single system of care is—on its own—adequately prepared to help people with co-occurring disorders.

Providing the appropriate types of services (i.e., when and to what degree they are required) presents formidable challenges in public health settings. These challenges are intensified when coupled with the numerous barriers that often limit coordination and integration efforts, including:

- A lack of any significant connection between mental health and substance abuse provider and service programs
- Separate, and often unequal, public and private health insurance benefits for the treatment of mental and substance abuse disorders
- The lack of a single center of responsibility for the treatment of individuals with co-occurring disorders
- A shortage of training opportunities, creating a situation whereby too few staff are trained in treating both mental and substance abuse disorders
- Differing treatment philosophies in the mental health and substance abuse treatment fields
- A reluctance by clinicians to address co-occurring disorders, particularly when one of the disorders is in an area in which the clinician is untrained
- Too little research-based guidance for the treatment of people with less severe co-occurring disorders
- Limited staff assessment skills and the infrequent use of assessment/screening tools that can accurately identify co-occurring disorders
- Funding shortages for substance abuse and mental health treatment in general and for co-occurring disorders in particular
- Differences in the ways States fund and regulate care (and in some cases, differences between counties and regions within the same State).

Despite all these barriers, numerous programs and systems of care—many of them community-based—are successfully operating. The Substance Abuse and Mental Health Services Administration commissioned this project to identify how they have been able to surmount obstacles and provide coordinated care for this vulnerable population. To minimize misperceptions, promote inclusion, and ensure that

the full range of successful programs were considered, SAMHSA contracted with two of the Nation's leading nonprofit associations to conduct research and prepare this report:

- The State Associations of Addiction Services is the only national organization of State alcohol and drug abuse treatment and prevention provider associations, representing 33 such groups in 29 States. As a result, SAAS has ongoing access to thousands of community-based substance abuse programs across America.
- As the country's largest and oldest membership organization of its kind, the National Council for Community Behavioral Healthcare is dedicated to ensuring that everyone can access appropriate and affordable community-based mental health and substance abuse treatment. Built on a network of 750 member organizations in 39 States, the National Council is committed to creating and sustaining communities that are healthy and secure.

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Methodology

As a first step, SAMHSA, SAAS, and the National Council educated their members about the project to ensure they fully understood its overall goals. With this preparation, they were able to help identify and solicit potential candidates for two distinct expert panels and for telephone interviews. As a result, leading thinkers on co-occurring disorders from across the Nation participated in the project.

For the first panel, SAAS and the National Council asked their members to identify program representatives, consumers, and experts who could provide insights on program-level issues. The first expert panel focused on how providers can initiate and sustain programs—identifying barriers and strategies for overcoming them and highlighting the necessary supports, including staff training and curricula needs.

Two months later, SAAS and National Council members helped identify State-, regional-, and county-level managers and other systems experts for the second panel. This group of experts would focus more on administrative perspectives, concentrating on how to create and sustain systems of care that foster coordination and continuity between treatment providers and programs.

SAAS and National Council members canvassed providers, consumers, and experts in their States to identify diverse representatives at both the program and systems-of-care levels. This process involved telephonic, electronic, and written communication with providers and organizations that fund systems of care for people with co-occurring disorders. They also sought nominations from experts who could recommend programs and systems that were in various stages of development. More advanced methods included meeting with representatives from organizations specifically concerned with this issue. For example, one State association's dual diagnosis committee took responsibility for nominating and prioritizing the most suitable experts within the State.

Using the Co-Occurring Disorders by Severity Matrix (Appendix A), nominators had to provide information on the nature and severity of the co-occurring disorders that the nominees treated. To provide detailed information about a nominee's associated program, nominators had to complete a standard nomination form (Appendix B). This form also requested that the nominee attach program brochures and other evidence of his or her program's effectiveness, such as published outcomes and evaluation reports. To address a different project goal, this form also requested that nominees provide names of and/or copies of co-occurring disorder training curricula (Appendix F).

Because many States nominated multiple individuals, SAAS and National Council members used a special screening process to establish a final slate of participants. Although informal, the screening criteria generally included the following:

- Degree of the nominee's expertise
- Diversity of the populations that the nominee's treatment program serves
- Willingness and availability of the nominee to participate during the scheduled timeframes.

The first criterion—the nominee's degree of expertise—was not itself sufficient to guide the selection process. Many individuals were identified as experts, and determining who had the most expertise was difficult. To narrow the list of possible participants, SAAS and National Council members made followup calls to nominees and further reviewed their resumes and their references from colleagues.

The second criterion—the diversity of the populations served by the nominee's treatment program—proved to be one of the most useful variables in the selection process. The nomination form provided information about the demographic diversity (e.g., age, race, gender, area of residence) of the co-occurring populations that the nominee served.

As an attachment to each form, the Co-Occurring Disorders by Severity Matrix helped nominators describe the problem severity diversity of the nominees' programs. This matrix is based on the following categories:

- Less severe mental disorder/less severe substance abuse disorder
- More severe mental disorder/less severe substance abuse disorder
- Less severe mental disorder/more severe substance abuse disorder
- More severe mental disorder/more severe substance abuse disorder.

SAAS and National Council members made a conscientious attempt to create panels that reflected various demographic characteristics and problem severity categories.

The third criterion—the nominee's willingness and availability to participate in the expert panel during the scheduled timeframes—was also an important consideration. Some individuals possessed the requisite background but were either unavailable on the scheduled dates or reluctant to participate for other reasons.

When scheduling was the issue, SAAS and the National Council made efforts to capture as much input as possible via telephone interviews. When individuals were reluctant to participate, SAAS and the National Council tried to identify the reasons and attempted to reduce these barriers. Some individuals expressed concern over the recording methods that would be used during the expert panel meetings. For example, some said their ability to offer candid opinions would be restricted if their remarks would be formally attributed to them. Others were worried that their opinions and recommendations may not be representative of their employers. SAMHSA project officers and representatives and Dr. Ken Minkoff—a nationally renowned expert on co-occurring disorders—reviewed the final slates for each panel. The process helped solidify the final selections and a few backup nominees to fill in should there be cancellations. To enable each expert to participate fully, each panel had a maximum of 12 people, thus promoting open dialog. (Please see Appendix C for participant profiles.)

SAAS and the National Council conducted telephone interviews with the experts who were unable to attend a panel in person or who could enhance expert panels with their specific knowledge and/or experience. It should be noted that although some gaps needed to be filled, the actual number of phone calls was lower than originally expected.

Both expert panels met in Washington, D.C.—the first in February 2001 and the second in April of that year. For a summary of the important findings from these panels, please see Appendices D and E of this draft report.

Key Lessons

CHAPTER 3

A common assumption heading into this project was that there are insurmountable barriers to providing integrated treatment for people with co-occurring disorders—especially funding barriers. As a result, both the expert panels and telephone interviews were structured to elicit discussion of these barriers.

The information gathered via this project, however, tells a very different story. Without a doubt, funding and regulatory issues, tight labor markets, and the historical differences between the fields of mental health and substance abuse can cause difficulties in establishing and sustaining successful treatment programs for people with co-occurring disorders.[1] Yet every day across America, providers and systems administrators use their perseverance, creativity, and leadership to minimize, sidestep, and/or overcome these types of obstacles. Consequently, this project offers a crucial overarching lesson: *These so-called barriers are not insurmountable*.

Five specific lessons from this project—outlined below—build on this premise. In this chapter, examples and quotes from the participants help illuminate these lessons.

1. There are many replicable strategies and tools—often simple and inexpensive—that people in the mental health and substance abuse treatment fields can use to successfully provide treatment for people with co-occurring disorders.

2. Leadership is a key ingredient for ensuring progress at both the provider and systems levels.

3. When initiating and sustaining programs and systems, it is important to involve numerous stakeholders, including consumers and family members.

4. On the whole, provider-level programs are further developed than systems-level initiatives.

5. Demographic differences (e.g., geography, populations served) and differences between types of providers (e.g., mental health/substance abuse, hospital-/community-based) appear to bear little significance when developing and sustaining treatment programs and systems of care for people with co-occurring disorders. By contrast, State and county benefit packages and the regulatory environment appear to be much more significant variables.

Together, these lessons highlight that providing integrated treatment for people with co-occurring disorders is becoming an expectation within quality care.

"We don't really have to wait for more money to do this job right, we just have to focus on one and one makes three."

Lesson One:

There are many replicable strategies and tools—often simple and inexpensive—that people in the mental health and substance abuse treatment fields can use to successfully provide treatment for people with co-occurring disorders.

Participants identified many strategies for initiating and sustaining programs and systems of care for people with co-occurring disorders. Sometimes, however, initiating a program or system can require different approaches and skills than are needed to maintain or grow it. (When applicable, the following sections note this distinction.) The following eight strategies address that issue:

1. Start with what you know and build from there. Many of the success stories at both the provider and systems levels evoked this simple premise. Instead of starting an entirely "new" program, this strategy enables programs and systems to build on their current knowledge, skills, and strengths while expanding gradually, for example:

- An addictions detox provider bolstered the program by adding a trained mental health professional for treatment and consultation.

- A hospital-based mental health program reversed an old policy and began accepting patients with a co-occurring substance abuse disorder.

1 Detailed lists of barriers, as described by the expert panelists, can be found in Appendices D and E of this draft report.

"We said we're going to use the existing community infrastructures. Instead of developing new residential programs, we used the existing program and added one staff member in there. Instead of developing a whole new system for the mental health agency, we put one (substance abuse) counselor in here."

"So what we look for is interagency initiatives which require little or no money, which require a lot of collaboration, and just building on very carefully what we're doing already, that we could just do slightly differently."

- A halfway house and a mental health clinic formed a partnership to provide more care for their mutual clients.

- Rather than building new clinics or programs, a large metropolitan public provider used its existing community-based mental infrastructure as a foundation for its co-occurring disorder initiatives. This provider used State demonstration grant money to foster training, coordination activities, and specialized services.

- Many systems administrators, especially State and county purchasers, convened workgroups from across funding lines to discuss clearly identified problems. Workgroups cochaired by staff from both substance abuse and mental health fields can often clarify problems and identify the best solutions.

- Some State and county systems administrators responded to pressure from criminal and juvenile, child welfare, and other service systems by developing pilot programs that worked across traditional barriers.

- A number of systems administrators studied data that highlighted how some difficult clients were doing better than others and found common treatment themes in both mental and substance abuse disorders. These administrators then championed these programs as best practices from which others could learn.

2. *Use an incremental approach.*

An incremental approach enables individuals, programs, and systems to build confidence as they take on the task of providing treatment to people with co-occurring disorders. Incremental approaches also made the transitions much easier for both clients and staff members, greatly decreasing the providers' sense of being overwhelmed. For systems, an incremental approach enhanced planning and provided time to change regulations, purchasing requirements, and other potential obstacles, for example:

- A residential treatment program for people with substance abuse problems began accepting people with co-occurring disorders—one diagnosis at a time. It first accepted people with co-occurring schizophrenia and substance abuse disorders. Staff members learned about the characteristics of schizophrenia, the appropriate treatments and medications, and other necessary supports. As they gained competence and confidence in helping this population, they gradually added people with different diagnoses, gaining the knowledge and skills they needed at a manageable pace. This incremental approach allowed them to modify their program gradually, thus easing the transition for existing clients.

- Although recognizing that people with co-occurring disorders need an array of services, many participants suggested beginning with one or two services or programs and adding more gradually. This approach gives systems administrators time to work with their existing provider network[2] to expand staff and strengthen support tools in readiness for broadening treatment programs.

- Incremental approaches are also well suited to the fact that treatment facilities, programs, and individual providers often face vastly different licensing and certification standards. Participants stressed interim steps, such as simplifying and changing licensing and certification requirements for serving people with co-occurring disorders. They accomplished this in various ways, such as:

  - Employing both certified mental health and substance abuse counselors and helping them become dually certified

  - Encouraging governing bodies to meld regulations for facilities and programs seeking to become licensed in both mental health and substance abuse treatment (but it is vital that such facilities and programs "get the ball rolling" under the current guidelines)

2 Organizations, professional groups, or professionals that align themselves (or are chosen by a purchaser) in a formal or informal way to ensure a broad continuum of services to defined populations.

- Having systems administrators contract with two different agencies—each one providing a distinct mental health or substance abuse service but under the provision that they work together on joint clients.

3. ***Bring together existing local resources and personnel to provide seed dollars to develop a program or system.***

Although grants or demonstration funds are almost always welcome, participants in this project found ways to provide quality treatment without new fiscal resources. At both the provider and systems levels, they discussed the "savings" that occurred once their co-occurring treatment services were in place. Simply removing systemic and programmatic duplications led to financial savings that could be reinvested in treatment. Providers and systems taking the initiative to use existing funds more efficiently were also better positioned to acquire funds from other sources.

At the provider level, the type of savings depended in large part on how the programs were funded. Some programs saved money by reducing crisis expenditures, some reduced the number of rehospitalizations for which they were financially at risk, and others were able to leverage their improved efficiency to expand treatment without increasing staff. One program for co-occurring disorders reported getting a larger contract from a health maintenance organization because it reduced patients' use of costly emergency services.

At the systems level, most savings were realized by reducing expenditures on more intensive and expensive levels of care. These savings then became a source of funding for the programs' maintenance and expansion.

Funds for serving people with co-occurring disorders can also emanate from outside the traditional mental health and substance abuse public purchasers. Providers are able to contract with numerous public services (e.g., criminal and juvenile justice, education, child welfare, welfare-to-work programs) to serve people within their jurisdiction. State and county systems can take this approach a step further by implementing Intergovernmental Agreements (IGAs) or a Memoranda of Understanding (MOU). These cross-agency agreements can give the behavioral health system more funds to expand to better accommodate people with co-occurring disorders. Technically, these are not new funds; they were available within the public system.

Similarly, program and systems representatives examined methods of sharing human resources. For example, a mental health program and a substance abuse treatment program could both provide counselors to start a treatment group for people with co-occurring disorders. Likewise, an experienced clinical supervisor or psychiatrist could work with staff across programs. At the systems level, teams working on dual diagnoses draw from existing staff in different State or county departments.

4. ***Establish a colocation.***

Programs enjoyed more success when staff, clients, and treatment areas were geographically close together. They were least successful when staff and/or clients had to travel to different locations for various services—even when they were merely on different floors of the same building. Proximity enabled programs to create multiple strategies to provide more integrated treatments, for example:

- When mental health and substance abuse programs were merged to initiate programs or expand into new areas, colocation took many forms. Some of the more successful approaches included establishing joint supervision (e.g., coleaders or co-program directors from each program) and sharing office space.

- Sometimes colocation meant placing staff from one program into another environment. For example, mental health caseworkers were placed at a substance abuse detoxification, treatment, and followup facility. In a contrasting case, mental health and substance abuse counselors were placed at the local emergency room or county jail.

"And if you have a budget that never goes up—I mean, we've been operating under the same budget forever—and you're trying to make it go around as fairly as possible, it's in your best interest for people to get well or to need a less intensive level of services than they would need otherwise."

"I think the one thing that helped us was really just getting both staffs together and sitting down and talking. It's almost as simple as that."

"One of the myths I get back to again is, if I only had a single stream of funding, I wouldn't have these problems. Yet it flies in the face of everything we know about health care. We have all kinds of collaborative, cooperative relationships in health care. When I go to the hospital, I have a primary care clinician, but I'm going to see a specialist if needed. They don't have to pool their funded money to get paid."

Furthermore, a residential program hired a pharmacist, enabling clients to get their medications on site rather than having to be transported to a mental health facility.

- Providing onsite psychiatric consultation and treatment can be crucial. More access and availability problems arose when psychiatrists had to go "out of the way" to provide treatment. For instance, one program using psychiatrists from a hospital 4 miles away had difficulty maintaining regular psychiatric services for clients with co-occurring disorders. The situation changed when the program moved across the street from the hospital.

- Organizing regular joint staff meetings and training opportunities also increased the success of treating people with co-occurring disorders. By focusing on shared clients, staff members from mental health and substance abuse programs were able to bridge their differences of approach, philosophy, and professional background.

- Systems administrators also reported that joint training on serving people with co-occurring disorders was a key strategy to laying the foundation for future success.

- Many program representatives reported that staff from different programs and backgrounds needed to get to know each other personally as well as professionally. Opportunities to socialize (e.g., staff picnics, placing offices next to each other) helped foster teamwork and a healthy respect for different philosophies and skills.

5. Collect and use data on effectiveness.
Collecting and using data related to program effectiveness can help initiate and sustain treatment programs and spark systemic change. Indeed, many participants reported that data on relapse rates (i.e., how often a client returned to a more intensive level of care or resumed abusing substances) was often their first and most powerful measure. When they discovered that their treatment programs for co-occurring disorders reduced relapse rates, they had powerful tools for expanding their programs. By collecting this vital data, programs could seek other sources of funding and convince opponents of the validity of their approach to treating co-occurring disorders.

Successful programs and systems rapidly learned the need to measure many variables, including clinical, financial, and social effectiveness. At the systems level, for instance, data that demonstrated cost reductions and showed that clients experienced improved quality of life were powerful ammunition for additional systemic changes, especially for tackling difficult regulatory obstacles.

Participants stressed the importance of starting with simple, realistic expectations about using data, as existing information systems often capture only part of the story. For example, co-occurring treatment programs might not be able to access data about rehospitalization that is contained within the mental health data system. Likewise, privacy regulations intended to protect the confidentiality of people receiving substance abuse treatment might limit the amount of data available to a psychiatric provider. As a result, programs for co-occurring disorders, and systems seeking to evaluate their treatment and approaches, must often create their outcome measures and data sets.

6. Employ a problemsolving approach.
Successfully building programs and systems often requires taking a problemsolving approach—one that stresses being helpful instead of complaining. Participants at both the program and systems levels reported that this type of approach was often more powerful than approaches based on philosophy or need, for example:

- A rural substance abuse residential service noticed that its recidivism rate (i.e., the frequency of repeat admissions) was highest for clients who also had mental disorders. As a result, representatives offered to provide the local mental health clinic with a

substance abuse case manager to assist with these clients when they were released from the treatment center. They started with the more difficult cases, but when this dual approach showed results, a more formal treatment partnership was formed.

- Mental health professionals can provide training for substance abuse caregivers on how to handle disruptive behaviors.

- By working at a substance abuse treatment facility, a mental health case manager can develop relationships with clients before their release and help with discharge and transitional planning.

- Many programs for co-occurring disorders were created in response to clients' deaths or near deaths. For instance, a mental health patient can die from an overdose due to self-medicating, or a substance abuse client might commit suicide. Programs for co-occurring disorders are potential solutions to these types of problems.

7. Use assessment and other tools.

Specific tools for co-occurring disorders (rather than just mental or substance abuse disorders) can improve assessment, outcome measurement, service delivery, and other aspects of care at both the program/provider and systems levels. Most representatives report developing these tools in isolation, but this situation is beginning to change with better distribution and federally supported dissemination strategies. The following tools proved valuable in building and growing programs and systems of care for people with co-occurring disorders:

- **Common values and principles**—At the program level, common values and principles most often develop when mental health and substance abuse programs fused. As for systems—especially State and county systems—developing shared-value statements and principles is often the first step to bridging departmental and agency differences.

- **Core competencies**—Several States have outlined the core competencies needed to serve people with co-occurring disorders. These lists provide programs with roadmaps for selecting, training, and supervising staff and for developing treatment services.

- **Clinical/treatment guidelines**—An increasing number of scientifically based treatment and medication guidelines and best practices are emerging in the arena of co-occurring disorders. Some States and counties found that creating treatment guidelines was one of the crucial developmental steps in building a system of care. Historically speaking, treatment guidelines are usually derived from actual clinical practices and are then used to promote consistency across service delivery sites and individual providers. While only a few participants had fully implemented clinical guidelines, they all believed that these tools were important to have soon.

- **Assessment tools**—Many programs and clinicians may have assessment tools designed specifically for either substance abuse disorders or mental disorders. However, tools that can identify needs in both areas enable more integrated treatment.

- **Outcome measurements**—As another key tool, outcome measurements specific to the treatment of people with co-occurring disorders make it easier for both programs and systems to achieve progress. Accordingly, many organizations are starting to modify their single-focus outcome measurements to be more useful for treating people with co-occurring disorders.

- **Common vocabulary**—Programs and systems both reported the need to develop a common vocabulary. Indeed, terms such as recovery, relapse, community support, self-help, and consumer involvement are often used differently within the substance abuse and mental health fields. Many participants reported that the process of developing the common vocabulary sparked new training tools.

"I have three residential directors who actually sat down with our information technology person and developed their own database because they were so frustrated with what they were getting from the State. Now not only can they compare what's going on within their own programs, but they can compare data sets between the two detox programs or between the two transitional support programs so that we can really see who's doing better where."

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"I think the hardest question was determining what we need first. The challenge is to figure out in which sequence our needs must be met and what has to be sequenced and what can happen concurrently."

"But, you know, it's face time and it's legislation by anecdotes. And the anecdotes need to be mine."

"I think that it is incredibly important to have people who are in recovery and beyond the treatment process to speak about what it was like for them too."

- **Psychiatric services**—Participants from successful programs reported that having access to an experienced psychiatrist who understands how to treat people with co-occurring disorders was critical. Having such a professional on staff can promote even better results.

- **Consensus building**—SAMHSA Community Action Grants addressed the formal consensus-building processes by providing funds for developing and disseminating common language, values, and tools. The Community Action Grants also enabled States and counties to replicate the process, which has proven to be valuable in a variety of settings.

8. *Promote training.*

Participants often cited training—at all levels—as the most critical factor in building programs and systems of care. Whether geared to systems and program change or to staff development, training was most valuable as an ongoing process. This approach allowed staff to apply their existing skills and knowledge within an evolving environment, while gaining new knowledge and skills. Programs and systems found many training tools and strategies to be effective, for example:

- Increasing the attention paid to training issues took commitment from senior leaders of provider organizations and systems administrators. For instance, one State initiated a multiyear process of building readiness and staff competencies within its provider network.

- Training covers a wide range of activities, such as skill building, knowledge acquisition, and attitude shaping. Important areas include:
  - Common vocabulary (outlined above)
  - Different conditions and treatment approaches in both the substance abuse and mental health fields
  - Medications and their appropriate uses
  - Symptoms
  - Family support
  - Training for managers and supervisors on how to support co-occurring disorder programming.

- Several programs for co-occurring disorders successfully used "shadowing" and "buddy" training. In these models, new employees and transfers from single-focus programs learn from exemplary employees in programs for co-occurring disorders—usually for 1 week or more. This approach enables new employees to gain practical knowledge and skills and to learn about the program's culture and philosophy.

- In one State, new staff members rotate through co-occurring treatment programs, spending 60 hours in these settings as if they were clients.

- Taking exemplary staff from an existing setting and making them the core team is a useful strategy to expand programs for co-occurring disorders into new settings. This provided the new program with successful strategies immediately, enabling new staff to learn from the best.

- Many programs and systems enlist the help of local colleges and universities to develop staff training programs.

- Providing special training programs for behavioral technicians and encouraging staff to get certified in dual diagnosis can help overcome workforce shortages.

- Consumers and their family members can be powerful trainers and help initiate beneficial program and system changes.

- Physicians who have only worked in mental health settings often need training on the impact and interaction of medications for people with substance abuse disorders.

- Importing staff with experience in building and sustaining treatment programs for people with co-occurring disorders can jump-start the development process.

Lesson Two:

Leadership is a key ingredient for ensuring progress at both the provider and systems levels.

One of the most striking issues during the expert panels and telephone interviews was the role of individual leadership. At provider and systems levels, initiating and sustaining beneficial change required ongoing vision, perseverance, motivation, and hard work. Although not everyone working in the field has had leadership training, many leadership strategies can be used across the field of co-occurring disorders, for example:

- Many participants stressed the importance of taking time to build personal relationships when forging partnerships between treatment teams, programs, organizations, and public purchasers. They took time to seek out counterparts, listen to areas of concern (i.e., resistance), forge problemsolving coalitions, and discover common goals and values. They shaped relationships in both formal and informal situations, including task forces, negotiating meetings, private conversations, and shared meals.

- Successful leaders took a strong interest in setting the culture of their program or system. They established a "can-do" approach that strengthened problemsolving and created conduct norms to better define their organizations and cultures. These norms included rules such as:

  - "We will respect each other's backgrounds."
  - "We will not tolerate violence—in language or in action."
  - "We will find ways to learn from each other and embrace collaboration instead of seeing which side wins."

Leaders, particularly in provider settings, reported having to reinforce these values by disciplining employees who took competitive or disrespectful stances.

- Successful leaders also cultivated relationships with the "people at the top," including direct bosses, provider CEOs, State agency directors, and county health directors. Leaders kept these important people informed and helped strengthen their commitment to providing treatment programs for people with co-occurring disorders. Strong leaders also prepared these VIPs for possible disruptions or discontent during systems changes so that they would not be dissuaded. Moreover, leaders used data on program effectiveness and cost-efficiency to enlist stakeholder support for broadening and expanding these programs.

- For many participants, "people at the top" also included elected State and county officials as well as consumer and stakeholder groups. Educating elected officials and other people about financing needs and the potential results for consumers, their families, and communities—in language they and their constituents can easily comprehend—is a critical relationship-building skill.

- Leaders at both the provider and systems levels regularly commented that changes always took longer than originally planned. As a result, patience and perseverance were major components of effective leadership. At the same time, leaders must keep staff motivation strong by regularly stressing that, although things were moving slowly, there was still progress. During lengthy preparation periods, leaders frequently needed to reinforce the initiative's ultimate goals.

- Whether building and expanding systems of care or programs at the provider level, participants reported that stakeholder requirements can be overwhelming and complex. As one respondent said, "That's a struggle—do we just do it all at once or can we just bite off a small piece?" Despite working in complex systems, successful

"Over the course of the last 3 years, we've developed a shared philosophy among both chemical dependency and mental health about how we're both viewing this patient philosophically and how we're treating the individual."

"What helped me break through barriers between programs was solving problems for people. I was able to go to the treatment staff and say I can help you with that problem, and then I'm going to show you how to keep doing it so that you can keep solving that problem."

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leaders can maintain their focus and overcome these challenges by focusing on one task at a time.

Lesson Three:

When initiating and sustaining programs and systems, it is important to involve numerous stakeholders, including consumers and family members.

"We spent time developing a common language. For the substance abuse providers we had to differentiate what a hallucination is—how you differentiate that from an idea, what's the difference between a delusion and just a religious thought. We did the same thing on the mental side. When we talk about addiction, we're not making any distinction between a schizophrenic who has three beers a month and somebody who is drinking a quart of whiskey a day."

Two points on this topic stood out:

1. ***There is a broad range of stakeholders.***

- Within provider agencies, stakeholders include staff at all levels, especially those directly involved in delivering treatment. Employees in areas such as reception, billing, and information systems are also very important, as their work could affect programming success. Personnel who could refer consumers to the program for co-occurring disorders are also critical, as are those who could provide other levels of care.

- Many programs were initiated as partnerships between two or more provider organizations. The employees at these organizations were obvious stakeholders. More broadly, it is important to involve other provider organizations that could refer consumers and/or serve them and their families in other capacities.

- Consumers and family members who are or might be served by the program are key contacts. Especially at the systems level, consumer involvement and family member advocacy organizations are also critical for broadening support. These groups contributed in many ways, such as organizing advocates, providing testimony, raising awareness and money, and describing how treating people with co-occurring disorders can make a positive impact on voters and communities.

- Serving people with co-occurring disorders is a complex process at every level. Many people needing treatment require services for other needs, including criminal justice, domestic violence, homelessness, childhood and adult education, juvenile justice, child welfare, public health, and employment services. At the systems level in particular, stakeholders also include representatives from the police, emergency rooms, and the crisis system. Strong relationships with these stakeholders can lead to increased cooperation and new types of partnerships.

- Legislative and governing bodies, such as county boards of supervisors, mayors, or State lawmakers, are key stakeholders. By involving and educating them, many participants established greater support for a coordinated approach to serving people with co-occurring disorders.

2. ***A great deal of behavioral health history has involved building consensus with stakeholders before taking action.***

Many participants in this project described the importance of involving and informing stakeholders but also stressed that providers and systems should act before consensus is reached. The goals of interacting with stakeholders are to provide information and build relationships. One expert described this approach (in contrast to the consensus approach) as "inviting participation in the change process rather than in the design process."

Lesson Four:

On the whole, provider-level programs are further developed than systems-level initiatives.

There are many models and examples of successful treatment programs for people with co-occurring disorders. In fact, some treatment programs were established as long as 20 years ago. Some participants described programs that had failed after starting up but were rebuilt with a better understanding of what not to do.

Almost all participants had experienced several developmental stages within their own programs and regularly communicated with programs in their region and/or State, sharing stories, skills, and strategies. Respondents discussed how they got started and maintained their programs—growing, changing, and shaping them over the years. Programs and

systems can use this collective body of experience to initiate better treatment programs for people with co-occurring disorders.

This rich history also underscores the overarching theme of this report: Obstacles are not insurmountable. Many programs have had years to find ways to resolve or circumnavigate obstacles. Although more recent programs may still experience frustrations, they have "older siblings" they can turn to for strategies, advice, and support. Now there are numerous tools, including guidelines, curricula, and program definitions. As late as 10 years ago there were none at all. Current challenges, therefore, focus not on creating new models or tools but rather on applying what is known and quantifying results.

Conversely, most planned systems of care for people with co-occurring disorders, including State, county, and regional provider networks, are in their infancy. Only recently—within the past few years—have they crafted plans to maximize existing services, fill in gaps, and coordinate services that provide integrated treatment for people with co-occurring disorders.

Often these public purchasers had developmental plans that simply placed the substance abuse agency and the mental health agency in the same State department or division. Sometimes they were blended totally. Even with this administrative blending, two distinct provider networks often remained, separated by their contracts, licensing requirements, regulations, service definitions, and payment mechanisms.

Many counties and States are currently in the pilot or demonstration stage of developing their systems; others are in the planning stage, forming "dual diagnosis task forces." A few are now laying the groundwork among providers and stakeholders via training and knowledge dissemination. Although some are in the early stages of implementing proposals, others are just now ready to issue Requests for Proposals (RFP) and Requests for Implementation (RFI), soliciting proposals for developing, funding, and implementing programs for people with co-occurring disorders.

As a result, even the experts know less about which approaches will work best in initiating programs for co-occurring disorders at the systems level. Because there is a heavy emphasis on development, it is hard to make conclusions at this time about what will work best to sustain and grow these systems.

However, people developing systems should build on the best practices that are currently emerging in the field. Indeed, numerous models are materializing from the Comprehensive Continuous Integrated System of Care grants in at least 10 States. (Additional information on these grants is available on SAMHSA's Web site at www.samhsa.gov.)

In States with strong county-level systems, counties may be at different points than their State funders. Some county systems are ahead; others lag behind. These differences arise, in part, because many counties have a history of providing direct treatment as well as being contractors and systems administrators. On the other hand, being smaller than their State counterparts, and enjoying greater geographic proximity to their provider networks, many county-level systems require fewer resources.

In any case, county-level systems and their regional provider networks are often in a blended position, with the difficulties and advantages of both providers and State systems. As a result of this complex mix, counties and regional networks may benefit from examples that are specific to their situations. These "in-between" systems have used a variety of strategies:

- Some counties purchase co-occurring disorder programming. Perhaps serving only a small number of people, they are significant nonetheless, representing a new category of service for the county.

- Other counties promote "capacity building" via contracting and purchasing. For example, one county systems administrator and purchaser described a gap analysis that demonstrated areas of need within their provider network. The county then used discretionary funds to develop programming to fill

"The first year we put $100,000 into training, the second year they told us we couldn't spend any money on training at all—it had to go to client services. But if I'd had my druthers, I would've spent another $100,000 on training."

in some of the gaps—increasing its capacity to build more co-occurring disorder programming.

- In some areas, counties selectively apply "waivers" for regulatory requirements, such as obtaining licensures to get a program jump-started. As one county director said, "Sometimes you just have to start serving the people and then fill out the paperwork."

- Some States are issuing RFIs and RFPs for county- and/or regional-level services; others are creating service definitions and reimbursement methodologies.

"Those are the three things: letting people talk it out, helping the lead person have a presence and a history on both sides, and getting people at the top to buy in."

Systems of care—whether at the State, county, or regional levels—actually serve as wraparound support. Even very successful programs may only provide two or three points on a continuum of care for people with co-occurring disorders. Without other treatment options to meet the consumer's needs before and after treatment, any program is less effective, leaving the consumer without necessary care. Fortunately, a system of care can identify programming gaps and then build treatment and support components that meet the most acute needs in a particular area.

On another front, many programs often face—and overcome—similar obstacles, including regulations and differing service definitions, licensing requirements, accounting standards, and workforce development strategies. County, regional, and State systems can help resolve or diminish some of these obstacles, leaving programs with more resources for delivering treatment.

Lesson Five:

Demographic differences (e.g., geography, populations served) and differences between types of providers (e.g., mental health/substance abuse, hospital-/community-based) appear to bear little significance when developing and sustaining treatment programs and systems of care for people with co-occurring disorders. By contrast, State and county benefit packages and the regulatory environment appear to be much more significant variables.

SAMHSA, SAAS, and the National Council went to great lengths to make sure this project reflected diversity, inviting a wide range of representatives to participate in the expert panels and telephone interviews. This goal was at least partially rooted in the assumption that differences among the representatives (e.g., geographic location, types of consumers they served) would produce significant differences in approaches, needs, and strategies.

Differences were noted, but a lot of common ground was revealed as well. For example, representatives from large, rural areas serving fewer than 20,000 people could often relate to the experiences of inner-city, minority providers who served populations larger than 1 million. Moreover, faith-based providers and State agencies faced many of the same challenges, and hospital-based programs discussed many of the same issues as community-based programs.

Therefore, although participants acknowledged the challenges of serving culturally, ethnically, and socio-economically diverse client populations, their bigger challenges lay in navigating the benefit and regulatory designs.

Benefit Design and Regulatory Issues

Significant differences did emerge when participants described the limitations imposed by State and county benefit packages and regulations. For example, some States have public mental health money available for treating only people with serious and persistent mental illnesses. Other States have broader definitions. These differences also affect how people with co-occurring disorders are treated.

Additionally, Medicaid—a major funder—pays differently in most States for mental and substance abuse disorders. Many States manage public funds for mental health differently from those for substance abuse. In fact, these funds are often managed by different agencies.

Some States delegate significant regulatory, licensing, and contracting authority to the county or regional level. Providers working across counties or regions in these States have to meet a larger variety of regulatory and contracting standards than providers in a single jurisdiction or in States that do not encourage more local control. County and regional systems administrators reported being "caught in the middle." They were tasked with building systems of care at the local level but had little or no control over State regulations or licensing requirements.

Without exception, participants expressed their frustration at regulatory and licensing requirements. There is an unwieldy number of service definitions, regulations, facility licensing requirements, rules for staff certification, and funding mechanisms at the county, State, and Federal levels. To make matters worse, they often contradict one another.

Participants referred to these disparities as some of their biggest challenges and wanted to make reducing and simplifying these requirements a top priority. One State is going to replace its tangle of local and State licensing and certifying requirements by turning to national accreditation. Participants applauded this strategy heartily.

Models

Due to the wide range of State and county benefit and funding design models, systems-level participants were almost unanimously in agreement on how to best use them. In short, they agreed that many models are most helpful when modified to reflect the specific conditions of the State and/or county—a better alternative than demanding strict fidelity to the original model. Although this adaptive approach can sometimes make researching effectiveness more complicated, participants believed that it increased the chance for success and provided opportunities to involve more stakeholders.

On another note, applying best-practice models enabled systems participants to focus on their main objective: to make funding and systems more efficient to better help people with co-occurring disorders.

"You need somebody who has knowledge on both sides and the respect of both sides, or it just won't happen."

Next Steps

CHAPTER 4

Based on the findings outlined in the preceding chapter, participants identified clear priorities and strategies to foster additional program and systems developments. These require the attention of decisionmakers at several levels, including SAMHSA, the Center for Medicaid and Medicare Services (formerly known as the Health Care Financing Administration [HCFA]), State and county mental health and substance abuse directors, Medicaid directors, and trade and professional associations.

The broad areas for action, discussed in more detail below, include:

- Dissemination and networking
- Program support
- Systems-level development
- Regulatory issues
- Workforce development
- Roadmap products
- Funding issues.

Some recommendations cut across several categories but are discussed under the heading that fits best. In some cases, no specific steps were outlined, but for areas that need more attention, participants stressed definitive steps.

Dissemination and Networking

Participants were hungry to obtain information about other programs and strategies and to share ideas and concerns with colleagues facing similar challenges. The following recommendations address these desires:

- Demonstrations, pilot projects, and research/demonstration grants can provide important lessons, but only limited circles of people know about them, especially at Federal and State levels. For example, State-level grant projects are rarely known in other States, but establishment of a central "library"—preferably a Web-based clearinghouse—would help make existing information more widely available. SAMHSA might be the best organization to implement this recommendation, with cooperation from State, county, and regional grantors.

- Enabling people who have successfully initiated and/or sustained programs to help others do the same, via face-to-face meetings, would be very beneficial. Participants found the interaction in this project stimulating and educational. In fact, they asked for more opportunities to meet representatives from other programs or systems that might be a step ahead of theirs—people they could call on for guidance. SAMHSA could implement these ideas at the Federal level, but they would also be extremely beneficial at the State level.

- Participants requested items such as:

  - Coaches/mentors, either informal or paid, who could help establish strategies, priorities, and next steps. These experts should be at least one step ahead of the person seeking the information.

  - Regular regional, State, and national meetings and teleconferences that would facilitate sharing of strategies and information. Participants asked for both formal presentations and planned opportunities for sharing among contributors at these meetings.

- Strategies for increasing networking among people at the county or regional levels should be explored. Their concerns often differ from those at other levels. This type of networking might be best organized by the Federal Government, by trade associations that have county behavioral health directors as members, and by States that are in the process of encouraging or requiring programs for people with co-occurring disorders.

"SAMHSA should just bring a group like this together periodically during the course of the year, because look at all the learning that can take place."

"If there's a pilot project, then you think about how you may replicate it—what are the things you're going to learn from that project—and be able to have a strategic plan in terms of what the next steps would be."

Systems-Level Development

Because systems development is in its infancy, a strong focus on growing the knowledge and skill base in this area is required. Strategies include:

- Finding ways to aggressively support the initiation and ongoing development of coordinated care systems, especially at the Federal and State levels, for instance:
  - Funding pilots in States with different types of benefit design and/or funding structures
  - Supporting person-to-person, State-to-State, and county-to-county networking, information sharing, strategy sharing, and tool development
  - Enhancing dissemination opportunities at the systems level, particularly with regard to effective strategies and tools.
- SAMHSA and other funders can target demonstration funding for building systems of care that can easily access:
  - Different funding mechanisms
  - Various provider panels
  - A range of prevention, early intervention, treatment, rehabilitation, and recovery services
  - Treatment for people in all quadrants of the Co-Occurring Disorders by Severity Matrix (Appendix A).
- SAMHSA and States could target research and demonstration projects to identify ways that systems can better provide coordination and wrap-around services to programs instead of just adding more layers of bureaucracy. These activities should focus on key issues, such as:
  - Providing a continuum of care and services
  - Making communication easier among different system components for both consumers and providers. With better communication, consumers would more easily move through care systems by using whatever providers and programs they need to address their disorders. Strengthened communication would also help providers better coordinate care for people with co-occurring disorders, who often need a variety of services.
- SAMHSA and States could develop resources for systems. (SAMHSA could focus on the State level, and States on their counties or regions.) Such resources include:
  - Model contracts
  - Network development strategies
  - Methods of modifying joint licensure/certification processes
  - Systemwide approaches to staff development
  - Involving stakeholders
  - Building on existing infrastructure rather that creating parallel systems
  - Monitoring and compliance issues.

Program Support

Participants reported that receiving grant money for demonstration projects or pilots was often a double-edged sword. They gained knowledge and skills and provided treatment to people who needed it, but the programs often disappeared at the end of the funding cycle. As a countermeasure, people should focus on sustaining and integrating these demonstration projects once funding has ended.

Similarly, demonstration and pilot projects often operated outside of the State or county local benefit and funding design, making them difficult to sustain once the Federal or special State funding ended. This

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problem might be alleviated by specific strategies for programs that operate within the State and local regulatory frameworks. An additional recommendation, building internal financial support to replace seed money and demonstration project funding, would also address this issue, for example:

- Using grants to facilitate large-scale change in organizations and systems to promote better integrated treatment for people with co-occurring disorders. The goal should be to make all mental health and substance abuse treatment programs "co-occurring capable."[3]

- Creating "knowledge and skill transfer" sections of a central Web-based library and fostering opportunities for face-to-face networking and conferences that focus on how to make programming for people with co-occurring disorders more financially viable.

- Helping programs—with specific supports and requirements—to convert these projects into ongoing business concerns once the demonstration/pilot funding is finished (for project funders).

- Building demonstration projects or granting seed money in conjunction with Federal, State, and local funders so that the Federal dollars are helping State and local working relationships to develop.

- Continue to focus on developing and widely disseminating tools to help initiate and sustain programs. Many outstanding tools are currently available, but there is a general lack of knowledge about them. Federal and State governments could assist with:

  - Clinical and practice guidelines
  - Models and effective language
  - Workforce competencies
  - Strategic planning models
  - Training materials for all staff and consumers
  - Easy-to-use and cost-effective outcome measures
  - Administrative and managerial guidelines for running or partnering with these kinds of programs
  - A list of frequently asked questions—and answers—about strategies for overcoming various obstacles.

Regulatory Issues

Both providers and systems representatives said regulatory and licensing contradictions and burdens were the most frustrating obstacles they faced. These burdens consumed valuable staff resources and created complications for blending services in sensible ways for the consumer. At all levels—national, State, and local—simplifying the tangled regulatory burden will go a long way toward promoting better care for people with co-occurring disorders. The recommendations include:

- SAMHSA could develop strategy toolboxes for State and local people to clarify and/or reduce regulatory licensure and other funding inconsistencies, duplications, and roadblocks. Providing data on service outcomes from States that are moving to national accreditation in lieu of local licensing and certification would also be beneficial. In addition, data should be provided on the costs—both financial and in human suffering—of contradictory, overlapping layers of regulation, compliance, and audits. SAMHSA's technical assistance centers could also help in this area, including the Addiction Technology Transfer Centers (ATTC)—a nationwide, multidisciplinary resource that draws on the knowledge and experience of recognized leaders in the addiction field.

- SAMHSA could help interface with the key accrediting bodies, aligning organizational standards and treatment delivery. Also, facilitating dialog among accrediting bodies, regulators at

3 This approach will build on the American Society of Addiction Medicine's (ASAM) goal of making all addiction programs dual-diagnosis capable. ASAM publishes national guidelines for the placement, continued stay, and discharge of people with alcohol and drug problems.

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every level, and systems of care for people with co-occurring disorders would raise awareness of the need for streamlined and more applicable certification and accreditation standards.

"SAMHSA could approach the main professional associations in psychology, social work, and substance abuse about the fact that a large percentage of the people we're serving are co-occurring and explain that curricula and certification processes should be adjusted so that people are coming out of school with knowledge on that subject and are expected to get updated."

Workforce Development

Programs and systems of care are not alone in their struggle with workforce issues. In fact, they plague behavioral health and health care, along with other service industries nationwide. But programs serving people with co-occurring disorders encounter workforce issues that go beyond having to find qualified, caring people who are trainable and are willing to work for relatively low salaries.

Participants noted that many local settings try to develop a trained workforce to serve in behavioral health care settings and, more specifically, in programs for co-occurring disorders. In many cases, it is inefficient for local programs to create a workforce. Programs for co-occurring disorders often must retrain their existing behavioral health care workforce.

Federal and State assistance is important to build up the number of caregivers who are knowledgeable in delivering care to people with co-occurring disorders. This process must incorporate both classroom-based education as well as on-the-job skill and attitude development. (This is different from orientation, in-house training programs, and broad-based State training that is meant to foster systems change.) This area requires more attention, but the following strategies may be beneficial:

- SAMHSA, perhaps in conjunction with broader Health and Human Services (HHS) leadership, could initiate dialog with professional associations, including the American Psychiatric Association, the American Psychological Association, and the National Association of Social Workers. Such dialog may produce ways of increasing the focus on serving people with co-occurring disorders via core curricula and postgraduate training internships.
- SAMHSA could explore ways to promote dialog among community colleges and other educational facilities. Such a process would help disseminate curricula and associate degree programs that prepare students for working in the field of co-occurring disorders. In fact, some participants had already developed local programs in their community colleges to train behavior technicians and other support personnel. SAMHSA is in an optimum position to promote this approach nationwide and could also help States build behavioral health curricula into their State university systems, incorporating courses and/or specialty programs. All behavioral health curricula should stress competency building.
- In conjunction with States, SAMHSA could convene meetings to discuss how to make it easier for people already certified in one field to gain certification as a co-occurring disorder specialist.

Roadmaps

This project revealed that people already know a great deal about initiating and sustaining programming for people with co-occurring disorders. There is a smaller but growing body of knowledge about "how to grow a system." Yet much of this information is unavailable—especially to newer programs. It is important then to develop products that will serve as "roadmaps," highlighting key decision points, resources, strategies, and potential landmines.

These products could be housed in a special section of the Web-based central library and might promote increased networking with existing programs.

Funding Issues

Although many programs and systems were able to overcome them, funding challenges are still very real and often complicate the processes of delivering treatment and building systems of care. Funding issues require more than just identifying where the money will come from and what it can be used for. Each funding stream—Federal, State, and local—carries its own accounting, documentation, licensure,

staffing, and other requirements and may define almost identical treatment in different ways. Moreover, funding streams may target different types of consumers and have disparate philosophies. Similar programs often have greatly different funding experiences.

The issue of funding is complicated by universal tension. From consumers to legislators, there is a tension between the desire for "pots of money" to treat specific populations and the desire to simplify how funding is administered.

Interestingly, funding is not necessarily a "problem to be resolved," but it is an area that would benefit from more coordination. This is especially true for systems that almost always require funding from multiple sources. Programs within SAMHSA are exploring this issue, and there are some other areas that are ripe for further exploration.

- Many States use Medicaid as a core component of their behavioral health funding. As a result, the Center for Medicaid and Medicare Services (formerly HCFA) should be invited to participate in dialogs with SAMHSA, State funders, State Medicaid directors, other significant funding sources, and trade and professional associations (especially those representing public purchasers). These discussions should focus on how to streamline and coordinate funding requirements for the following purposes:
  - Reducing the costs of administering the funds at every level
  - Increasing the amount of funding for treatment instead of administration and benefit coordination
  - Supporting local programs and systems of care by reducing the complications associated with accessing and using a variety of funding streams.
- It is also important to consider the Health Insurance Portability and Accountability Act (HIPPA), which protects workers and their families in terms of health insurance coverage. It also calls for the standardization of electronic patient health, administrative, and financial data as well as security standards to protect the confidentiality and integrity of "individually identifiable health information." Implementing HIPAA could produce mixed results in terms of the regulatory burdens for co-occurring disorder programs and systems.
- HIPAA may ease some obstacles by standardizing electronic transaction processing. Items such as claims, service authorizations, referrals, and other electronic transactions should become consistent across disorders, thus reducing paperwork. However, HIPAA and 42 CFR-part 2 (the Federal confidentiality section of the Substance Abuse Patient Records Statute) are inconsistent on their requirements for privacy and for the consent and authorization needed to release information by patients. In other words, programs serving people with mental disorders have different requirements than programs serving people with substance abuse disorders.

This situation is complicated by a variety of State laws that govern privacy for people seeking substance abuse treatment. SAMHSA reconciled the privacy, consent, and authorization requirements contained within both 42 CFR-part 2 and HIPAA and posted this work on its Web site in fall 2001. Followup clarification and additional dissemination activities would be helpful.

Glossary

Accreditation An extensive process whereby health care and behavioral health care organizations apply, are surveyed, and receive certification for a set time period, indicating they meet established national standards. The lengthy process involves policy development and standards of care based on strategic planning, system/organizational monitoring, and continuous improvement. The Joint Commission on Accreditation of Healthcare Organizations, the Rehabilitation Accreditation Committee, and the National Committee for Quality Assurance are examples of national organizations that provide accreditation.

Clinical Guidelines A set of clinical standards that defines best practices for a particular disorder. These standards can help evaluate treatment outcomes.

Continuum of Care An array of flexible service options designed to meet the needs of people with substance abuse and mental disorders. Treatment within the continuum ranges from least restrictive (outpatient) to most restrictive (inpatient) settings and is available to individuals based on clinical need during the course of treatment. (See System of Care.)

Co-Occurring Disorders Substance abuse and mental disorders that affect an individual simultaneously. In many cases, the disorders are not treated in an integrated way, leading to less than desirable outcomes. Co-occurring substance abuse and mental disorders are discussed in this report. However, outside of this report, the term can refer to other pairings of disorders.

County-Level Systems The systems of care provided by counties, either directly or through subcontracted relationships. (See System of Care.)

Gap Analysis A formal needs assessment that looks at existing systems of care in conjunction with the needs of particular populations. The findings from a gap analysis help determine necessary treatment services and enhancements, geographic accessibility, cultural barriers, and more. This process is critical for purchasers when developing RFPs. Providers and provider networks can also use this information to strengthen their systems.

Health Insurance Portability and Accountability Act A complex set of Federal regulations and requirements intended to protect the security and confidentiality of health care information. Created in 1996, these regulations focus on policies, procedures, and data transactions within and across health care and behavioral health care organizations.

Intergovernmental Agreements Usually a formal agreement between two or more government entities. These agreements describe the responsibilities each entity will assume in a coordinated effort to affect service delivery to defined populations.

Level of Care A specific type of service intended to meet the medical and clinical needs of an individual with a substance abuse or mental disorder. Examples include outpatient, partial hospital, and residential. (See Continuum of Care.)

Memorandum of Understanding	An agreement between two or more organizations to define a given relationship and each party's responsibilities within the agreement. (See Intergovernmental Agreements.)
Outcomes	The desired results of a treatment intervention. Outcomes are measurable and should demonstrate whether a particular treatment goal was achieved. Outcomes can be individual or aggregate indicators of the level of success achieved during and after a particular treatment intervention.
Provider	A contractor or subcontractor who treats people with mental or substance abuse disorders. Usually, providers are community-based, for-profit, or nonprofit, but government agencies that assume the role of direct service delivery are also in this category.
Provider Network	Agencies, professional groups, or professionals that align themselves in a formal or informal way and provide a continuum of treatment services to defined populations.
Public Purchaser	Mostly governmental entities that secure subcontractors through a procurement process and pay them to provide treatment to defined groups or populations.
Reimbursement Methodology	The method for reimbursing providers for treatment delivery. There are a variety of ways to align payment with service delivery, including fee-for-service, capitation, and case rates.
Request for Information	A process that enables purchasers to gather information from potential providers. An RFI can help a purchaser assess a provider's capacity, experience, and interest in delivering a particular service or continuum of treatment services.
Request for Proposal	A process for purchasers to formally obtain a proposal from parties interested in delivering treatment. This competitive process usually results in the selection of one or more specific providers to deliver treatment through contractual arrangements.
Service Definitions	The operational definition of specific treatment services that correspond to particular billing codes. These codes become the mechanism for reimbursement.
Stakeholder	Individuals or groups with an interest in the development, implementation, monitoring, and impact of treatment/support services.
Systems Administrators	Administrators involved in overseeing a comprehensive continuum of treatment delivered to a defined population. (See System of Care.)
System of Care	A comprehensive continuum of mental health, substance abuse, and other support services coordinated to meet the multiple, changing needs of people with substance abuse and mental disorders.
Systems Level	The public purchaser—usually the State mental health agency and the State substance abuse agency—responsible for creating systems of care in partnership with counties, regional authorities, and provider networks.

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Co-Occurring Disorders by Severity Matrix

Participants in this inquiry used a four-quadrant severity matrix to categorize the co-occurring populations they serve. The idea to use this matrix as a tool emerged from discussions between the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD).

The matrix represents an initial effort to create a unifying language among service providers in the area of co-occurring disorders. The quadrants identify the continuum of these disorders as follows:

I **Less severe mental disorder/less severe substance abuse disorder**
II **More severe mental disorder/less severe substance abuse disorder**
III **Less severe mental disorder/more severe substance abuse disorder**
IV **More severe mental disorder/more severe substance abuse disorder**

Figure 1: *Quadrants describing the continuum of individuals with less to more severe mental disorders and less to more severe substance abuse disorders.*

The matrix helped identify participants who serve diverse populations and clarified language within the expert panels and interviews. It also served as a framework for focus group participants to describe their agencies' services and clients.

On June 16 and 17, 1998, NASMHPD and NASADAD cosponsored the *National Dialogue on Co-Occurring Mental and Substance Abuse Disorders*. The meeting was supported by the Center for Mental Services (CMHS) and the Center for Substance Abuse Treatment (CSAT) of SAMHSA.

Participants developed a national framework for considering the needs of people with co-occurring disorders and the systems-level requirements to address these needs. This new framework is similar to one developed in New York that determines the location within the service system in which people receive care (e.g., primary health care, substance abuse programs, mental programs) based on the severity of their problems.

National Dialogue participants expanded on the New York model to include several noteworthy features. For instance, the revised framework now:

- Is based on symptom multiplicity and severity, not on specific diagnoses
- Uses language familiar to both mental health and substance abuse providers
- Encompasses the full range of people with co-occurring disorders
- Identifies windows of opportunity within which providers can act to prevent symptoms from becoming more severe.

SAAS and the National Council used the graphics version of this national framework to support the panels' nominee selection process. It also helped guide discussions, particularly in the first panel meeting. For both the screening and panel discussions, the selected expert panel members represented diversity in terms of the consumer populations they served, recognizing that barriers and solutions differ between the various levels of problem severity.

Nomination Form

Focus Group To Identify Barriers to Implementing Effective Treatment for Individuals With Co-Occurring Disorders

Name: _____

Title: _____

Organization: _____

Phone: _____ Fax: _____

E-mail: _____

Co-Occurring Disorders by Severity Matrix

Please review the grid below and circle the severity quadrant that is **most applicable to the individuals served** by the program or person being nominated.

I **Less severe mental disorder/less severe substance abuse disorder**	**III** **Less severe mental disorder/more severe substance abuse disorder**
II **More severe mental disorder/less severe substance abuse disorder**	**IV** **More severe mental disorder/more severe substance abuse disorder**

Setting of Your Organization (circle one): Rural Urban

Description: _____

_____

_____

_____

Describe the Co-Occurring Treatment Program (attach additional pages if necessary):

_____

_____

_____

_____

Describe Evidence of Effectiveness (attach additional pages if necessary):

_____

_____

_____

_____

Any Additional Details About the Co-Occurring Population Served (e.g., adolescents, adults, women, racial minorities, all populations, etc.):

_____

_____

_____

_____

Profile of Participants in Expert Panels and Telephone Surveys

APPENDIX C

Expert Panel I: 12 Participants
Representing providers: 11
Parent of consumer: 1
States represented: PA, WI, AZ, TX, RI, MN, MI, NY, MA, CA, FL
Providers serving children and adolescents: 4
Medical director: 1

Expert Panel II: 12 Participants
Representing providers: 3
Representing State mental health or substance abuse agencies: 4
Representing county MH/SA agency: 1
Representing regional advocacy group: 1
Representing MH/SA trade association: 1
Representing regional network: 1
States represented: AZ, ME, FL, PA, NY, MA, KS, OH

Telephone Contacts
County mental health/substance abuse directors: 2
State medical director: 1
State MH director: 1
Physician/consultant: 1
Statewide network contractor: 1
Consumer consultant to States on program development: 1
Multicounty provider network: 1

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Findings From Expert Panel I

I. General Factors for Initiating Co-Occurring Programs

A. Critical issues or events

B. Clinical/practitioner/payer identification of needs

C. Mandate from payers and public authorities

D. Data showing the costs of recidivism for specific populations

E. Funding and grant availability

F. Leadership

II. Key Issues That Impact the Design and Implementation of Programs and Systems

A. Funding

1. Categorical funding—funding restricted to specified populations

B. Distance between mental health and substance abuse professionals and/or sites (always a problem if either the clients or the service providers have to travel between sites)

C. Workforce issues

1. Lack of trained staff
2. Difficulty finding able and willing psychiatrists
3. Finding staff who can learn treatment modalities and be client centered
4. Service providers who do not see or identify a need for co-occurring disorders treatment

D. Regulatory/funding/administrative requirements

1. Site certification differences (State and local levels)
2. Separate funding streams, with separate accounting, audit, and other requirements
3. Separate regulatory systems and requirements
4. Separate State/county data systems, making it difficult to obtain good data about co-occurring disorders within existing systems—many programs had to build their own (i.e., unfunded mandates)
5. Diverse legal confidentiality requirements
6. Regulations and/or funding requirements addressing abstinence
7. Difficulty getting permits for facilities
8. Lack of standardized accreditation for co-occurring disorders programs
9. A greater number of "hoops to jump through" than for single-diagnostic programs

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E. Continuum of care issues

1. Limited access to psychiatrists when individuals are in crisis
2. Lack of detox facilities and payment
3. Lack of a co-occurring continuum of care and services
4. Limited followup funds and programs

F. Wraparound services issues

1. Lack of funding for family treatment
2. Lack of access to medical care and all ancillary services
3. Cost of prescription medications
4. Lack of supportive housing
5. Lack of transportation, especially when services are geographically diffuse
6. Lack of child care

G. Service delivery issues

1. Lack of clinical practice guidelines
2. Disagreement within and between fields as to appropriate treatment modalities, lengths of stay, etc.
3. Lack of respect between fields
4. Rigid treatment modalities (i.e., therapeutic communities) in either service area
5. Fixed lengths of stay
6. Closed referral system
7. Limited research, especially on special populations like adolescents and transitional-aged youth
8. Lack of standard, effective outcome tools
9. Caseload management
10. Lack of informative material for staff, clients, and families

H. Organizational issues

1. Outdated provider organization policies that do not support treatment and programs for people with co-occurring disorders
2. Many small organizations involved—difficulty accessing capital to upgrade infrastructure

III. Effective Strategies for Overcoming, Avoiding, and Defusing Barriers When Initiating Programs (Beginning With What You Know and Growing It)

A. Patching together local resources, existing resources, and personal, which can provide seed dollars

B. Increasing awareness of client needs among direct service providers so that they support the programming (at least in theory)

C. Proximity/colocation

1. Joint staff meetings between and among organizations that are partnering
2. Staff from each specialty colead all programs and groups
3. Staff from one program in the same location as staff from another (i.e., mental health case work located at a substance abuse treatment facility)

D. Understanding that it takes time

E. People who can serve as "bridges" between groups

F. Data on effectiveness

1. Data on relapse rates often comes first—either for substance abuse or hospitalization or even more intensive treatment

G. Assuming a problemsolving approach in working with other organizations, divisions, units, and programs

1. Provide services in other organizations, helping them with their problems
2. Starting with "toughest" clients can show dramatic improvements quickly

H. Build on individual and organizational relationships

I. Incremental implementation—helps with mastery, decreases sense of being overwhelmed, and eases staff and client transitions

1. Incremental inclusion of a mental health diagnosis into substance abuse programs
2. Incremental programming

J. Steady, supportive, and proactive psychiatrist who knows both areas

K. Assessment and other tools

1. Outcomes
2. Clinical guidelines
3. Vocabulary

IV. Supports for Effective Programs

A. Supports for program initiation

1. Consumers and family members who help raise awareness and money
2. Put as much money and energy as you can into staff training
3. Import staff, especially in leadership positions
4. Administrator and CEO support, from all agencies if possible
5. Take core staff from existing programs and use them to open new programs—infuses competency, confidence, and culture

B. Supports for program continuance

1. Put as much money and energy as you can into staff training
2. Ongoing supervisor training (supervisors need to make it part of the culture)
3. Developing and nurturing program culture
4. Opportunities for staff to socialize together at all levels (e.g., picnics, graduation)

C. Source of needed supports

1. Federal Government
   - Disseminating information to a wide group (e.g., current findings and lessons from pilot projects, demo projects, research grants, meetings)
2. State
   - State trade associations coming together and working on joint projects
3. Level not important
   - Peer mentoring on starting, building, and running a co-occurring disorders program—networking

V. Other Findings

A. Descriptions of unserved or underserved populations

1. Middle of quadrants (people who cluster near the center line)
2. Children
3. Children of people with co-occurring disorders
4. Families of people with co-occurring disorders (e.g., spouses, parents, siblings)
5. Gay-lesbian-bisexual-transsexual
6. Transitional-age youth, 16-24
7. Specific cultural and linguistic groups (varies by location), usually based on a shortage of therapists who speak certain languages and/or who understand cultural issues
8. Tridiagnosed—substance abuse-mental illness-physical disability (physical and/or cognitive)
9. People in either the juvenile or criminal justice systems
10. Grey zone (i.e., too much to qualify for Medicaid/public funds, no health insurance, underinsured)
11. Noncustodial parents
12. People who do not meet rigid diagnostic standards to qualify for co-occurring programs
13. People who avoid treatment because of stigma
14. Homeless
15. Elderly

B. Description of growing and emerging populations

1. "Older people" – between 40 and 55
2. Younger people and children (should be doing treatment in elementary schools, not just awareness)

C. Gaps in service continuum and systems

1. Role of consumers and family members
2. Recovery models
3. Knowledge and skills

D. Core competencies needed for effective programming

1. ICRC core competencies (18) (Joe Hyde)
2. AZ DBHS-developed core competencies
3. MA-developed core competencies

E. Training and curricula

1. Harris County programs at the community college, the continuing education arm of the local university, and the nursing school to train and recruit staff
2. Los Angeles County dual diagnosis certification program (30 people at a time—half mental health, half substance abuse)
3. New York State example (staff members sit through programs as if they were clients—about 60 hours per employee)
4. Behavior tech training course (Project PARS)
5. Shadow training (Bay Cove)
6. Latino Counselor-in-Training Program (RI)
7. Rhode Island example (statewide curriculum committee—get input from actual providers, not just higher ups)

F. What is needed

1. Other knowledge and skills acquisition needs and strategies
2. Need staff who "play well with others"
3. Motivational interviewing that changed practices in Rhode Island
4. Need a best practice about when to start medication treatment on a patient following detox and other similar clinical guidelines

Findings From Expert Panel II

I. Early Stages: Initiation of Dialog–Leading up to Change

A. External factors

1. Suicides
2. Violence
3. Drug overdoses
4. Closure and/or transition from State hospitals to communities
5. Consumer dissatisfaction
6. Consumer/family stories
7. HIV/AIDS
8. Grassroots advocacy
9. Privatization of services
10. Managed care

B. Federal dialog

1. SAMHSA
2. CSAT/CMHS
3. Congressional activity
4. TIPs/TAPs
5. ATTCs
6. Transfer of technology
7. Funding priorities

C. Role of collateral systems

1. Mental health
2. Substance abuse
3. Child welfare
4. Juvenile justice
5. Adult corrections
6. Jails
7. Juvenile corrections
8. Medicaid authorities
9. Domestic violence
10. Other social service agencies

D. Counties

1. Relationship between counties and States
2. Role of counties as providers
3. Relationship between counties and regional systems
4. Role of counties as health providers

E. Regional models

1. Privatization
2. Provider collaboration
3. Local emphasis
4. Potential efficiencies

F. Customer demands

1. People in collateral systems not happy
2. Consumer/family dissatisfaction
3. Criteria for satisfaction
4. Necessary responses
5. Who needs to be at the table

G. Other external forces

1. Mental service planning councils
2. Professional and trade associations
3. Colleges and universities
4. Drug and mental health courts
5. Related community resources

H. Internal dialog (how to best serve people with co-occurring disorders)

1. Diagnosis versus function
2. Problem identification
3. Workgroups
4. Study sessions
5. Task forces
6. Role of crisis systems
7. Defining collaboration (administrative and clinical)

I. Role of leadership

1. Factors that affect leadership
2. Convening dialog
3. Defining vision and values
4. Best practices
5. Research to practice
6. Standards of care
7. System mandates
8. Steps necessary prior to MOUs and IGAs
9. What should collaboration look like

II. Barriers to Change

A. Regulatory barriers

1. Licensure regulations
2. Legal mandates of various State agencies
3. Different policies and procedures
4. Different operating guidelines
5. Medicaid regulations
6. Lack of clear guidelines for developing IGAs and MOUs
7. Categorical funding
8. Legislative rules and regulations
9. Procurement regulation

B. Agency barriers

1. Diagnostic criteria
2. Different funding requirements
3. Agencies not working together
4. Different agency mandates (e.g., child welfare, corrections, treatment)
5. Turf battles
6. Friction between State, county, and local jurisdictions
7. Bureaucracies interfering with work in the trenches
8. Tendency to make questionable requirements
9. Accountability more complicated than necessary
10. Data systems not compatible or unable to communicate
11. Specific procedure codes for reporting services not always compatible

C. Organizational barriers (provider)

1. Different organizational cultures
2. Licensure requirements
3. Accreditation
4. Training needs of staff at all levels
5. Managed care not always flexible or compatible with changing needs
6. Overwhelming paperwork requirements
7. Workforce issues—availability of qualified, competent staff
8. Midlevel management training not always available
9. Current knowledge and research from the field not always available

III. Strategies for Overcoming Barriers

A. Programmatic and systems strategies

1. Start small—pilot and demonstration projects
2. Collaboration with other agencies and provider systems
3. Cross-training
4. Engage willing partners for collaboration
5. Create staff and provider incentives
6. Collaborative multidisciplinary teams with families and consumers
7. Network development
8. Home-grown provider networks
9. Keep systems local and community-based
10. Parallel agencies coming together
11. Utilize multiple contracts to create greater flexibility
12. Dual licensure

B. Funding strategies

1. Pool resources to build pilot and demonstration projects
2. Utilize procurement process to align desired system changes with funding
3. Utilize MOUs and IGAs that can evolve over time and facilitate system change
4. State procurements that structure funding for integrated and co-occurring systems, allowing for creativity
5. Using funding from one system to purchase and integrate services from another system
6. Flexible funding
7. Build a mosaic of funding

C. Opportunities for leadership

1. Use advocacy to foster change
2. Engage other leaders to move agendas forward
3. Apply external pressure in a positive way
4. Collaboration at the highest levels of leadership
5. Figure out what all sides need to move forward
6. Develop criteria for agreements/MOUs and IGAs
7. Keep your eyes on the big picture while taking small steps
8. Use licensure, procurement, payment methodologies, and policies
9. Public/private funding opportunity
10. Funding not the only solution
11. Expansion of covered services
12. Other forms of financing (e.g., cap)

IV. Supports Needed To Move Forward

A. Dissemination of research and best practices

1. State offices
2. National organizations
3. Trade associations
4. Universities and colleges
5. Accreditation organizations
6. TIPs and TAPs
7. Moving toward outcomes
8. Public health
9. State and national meetings
10. Technical assistance

B. Training supports

1. Cross-training
   - Corrections
   - Mental health
   - Substance abuse
   - Child welfare
   - Law enforcement
   - Domestic violence
2. Training throughout all organizational levels
3. Time off and other staff incentives
4. Training curricula and materials
5. Customized training
6. Clinical and administrative training and cross-training
7. Strategic planning
8. Mentoring

C. Workforce supports

1. Recruitment
2. Retention
3. Career ladders
4. Field placements
5. Training
6. Continuing education
7. Productivity
8. Cultural diversity and competency
9. Role of consumers and families
10. Procurement
11. Alternative financial models (local, State, and Federal)
12. Regulatory

D. Administrative supports (local, State, and Federal)

1. Licensing
2. Credentialing
3. Procurements
4. Alternative financial money
5. Regulatory changes
6. Legislative collaboration

Training Curricula

The State Associations of Addiction Services and the National Council for Community Behavioral Healthcare used a multifaceted methodology to create the following, one-of-a-kind collection of co-occurring disorder training materials.

SAAS and NCCBH polled their State association and provider members to identify training curricula that could help people develop core competencies. Participants in this project also made significant contributions. In addition, SAAS and NCCBH asked the people they initially polled to identify other experts who could recommend additional training curricula—a process that gave voice to State leaders.

As a final step, Dr. Ken Minkoff—a nationally renowned expert on co-occurring disorders—reviewed the list to make certain all items were on point. Although it is not exhaustive, this unique collection includes resources for beginner, intermediate, and advanced audiences in a variety of electronic and other formats. There are even programs that offer continuing education credits. Although some of the items on the list are free, others must be purchased.

The field of co-occurring disorders is rapidly evolving. As a result, it is likely that additional training materials will continue to emerge, and the SAMHSA Center for Mental Health Services Community Action Grants are potential sources of support. They enable communities to convene partners, build consensus, eliminate barriers, and adapt service models that meet local needs. Encouragingly, some recent grantees chose to focus on co-occurring mental and substance abuse disorders.

Two unexpected observations emerged throughout this project. First, although participants provided anecdotal evidence, there was a lack of any credible tools and effectiveness data to assess co-occurring disorder training curricula.

Second, many of the items in this compendium are geared to specific populations. Curricula for correctional populations were the most prevalent, whereas items for adolescents were the least prevalent. Some items deal with the needs of women and specific racial groups. However, there is an apparent need for more items to cover these areas.

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Training	Product Description	Source	Public Domain	Private Domain
OJP Onsite Training Programs	The "Training on Treating Offenders With Co-Occurring Disorders" program can be tailored to the specific needs of the requesting agency and delivered on site at a location provided by the requesting agency.	**http://www.ojp.usdoj.gov/cpo/conferences.htm** Office of Justice Programs	Yes	
The Gains Center technical assistance, curriculum development, customized training	Offers technical assistance to plan, implement, and operate appropriate, cost-effective programs. The Gains Center develops staff training curricula for States, localities, and criminal justice and provider organizations in the process of developing or implementing co-occurring disorder services for those in the justice system.	The GAINS Center 262 Delaware Avenue Delmar, NY 12054 phone: (800) 311-GAIN fax: (518) 439-7612 e-mail: **gains@prainc.com**	Yes	
Developing a Cross Training Project for Substance Abuse, Mental Health and Criminal Justice Professionals Working with Offenders with Co-Existing Disorders (Substance Abuse/ Mental Illness)	*This manual is available on line. A statement crediting the authors and The Information Exchange, Inc., must accompany any use of these materials.* The manual is split up into numerous Web pages because of its length (about 165 printed pages). The first section reviews literature concerning this population; the second section is a guide for setting up a cross-training project; and the third section is a model, 12-session curriculum that could be used for training professionals about this population.	Bert Pepper, M.D., and Edward L. Hendrickson, M.S. The Information Exchange, Inc. 120 North Main Street New City, NY 10956 1996 **http://www.toad.net/~arcturus/dd/ddhome.htm**	Yes (with author and source citation)	
Dual Diagnosis Part 1: Concepts and Treatment Issues	A 3-hour course that provides need-to-know information about dual disorders. Specific information focuses on the general treatment needs related to dual disorders as well as pharmacological management issues. *Cost: $40–Internet version; $55–hard copy format—instructor: Kevin Scheel.*	Hanley Hazelden online courses at the Hazelden Distance Learning Center for Addiction Studies **http://www.dlcas.com/courselisting.html** DLCAS P.O. Box 176 Center City, MN 55012-0266 phone: (800) 328-9000		Yes

Training	Product Description	Source	Public Domain	Private Domain
Dual Diagnosis Part 2: The Prevalent Disorders	A 3-hour course that provides detailed information about the more prevalent disorders in chemically dependent populations. The course includes specific diagnostic and treatment considerations for mood disorders, anxiety disorders, personality disorders, and psychotic disorders. *Cost: $40–3 hours–Internet version; $55–hard copy format—instructor: Kevin Scheel.*	Hanley Hazelden online courses at the Hazelden Distance Learning Center for Addiction Studies **http://www.dlcas.com/courselisting.html** DLCAS P.O. Box 176 Center City, MN 55012-0266 phone: (800) 328-9000		Yes
Chemical Dependency and Post-Traumatic Stress Disorder	The Addiction Technology Transfer Center of New England offers online education programs. The "Chemical Dependency" course provides an overview of the connection between Post-Traumatic Stress Disorder (PTSD) and chemical dependency. Both conditions are discussed as to their diagnostic criteria, presenting symptomatology, biological aspects, and predisposing variables.	Center for Alcohol and Addiction Studies Brown University Box G-BH Providence, RI 02912 (p) 401-444-1808 (f) 401-444-1850 **http://www.caas.brown.edu/ATTC-NE**	Yes	
Dual Diagnosed Treatment: A MAP to Recovery	The "Dual Diagnosed" course introduces and/or expands the clinician's knowledge of specific treatment approaches representing integrated treatment for people suffering with emotional and addictive disorders. It explores key factors in the recovery process, including methods for improving motivation, raising awareness levels, and focusing on skills training.	Center for Alcohol and Addiction Studies Brown University Box G-BH Providence, RI 02912 (p) 401-444-1808 (f) 401-444-1850 **http://www.caas.brown.edu/ATTC-NE**	Yes	

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Training	Product Description	Source	Public Domain	Private Domain
State of Arizona Service Planning Guidelines ***Co-Occurring and Substance Disorders (edited version) 2000*** ***Arizona Integrated Treatment Services Consensus Panel Training***	Though not truly a training manual, this service guideline document is a ready source of training information. This program describes the activities of the Arizona Integrated Treatment Consensus Panel, which developed the vision, principles, goals, objectives, and strategies for the long-term implementation of integrated treatment services in Arizona. The program describes the basic problems with the current treatment of individuals with co-occurring disorders and the strategies that have proven to be effective in improving treatment. It also delineates the vision and principles that were used to design an integrated delivery system. The course is an introduction to co-occurring disorders and is meant for all levels of staff. It lasts approximately 1.5 hours.	State of Arizona **http://www.treatment.org/Topics/AZ_guidelines.pdf** Authored by: Kenneth Minkoff, M.D. 12 Jefferson Drive Acton, MA 01720 781-932-8792, x311 **Kminkov@aol.com** Arizona Integrated Treatment Services Consensus Panel **http://www.hs.state.az.us/bhs/aitcp.htm**	Yes	
The Evaluation Center@HSRI Toolkit: Evaluating Substance Abuse in Persons with Severe Mental Illness	The Center offers the six following programs—all of which are designed to enhance evaluation capacity: 1. **The Consultation Program**—consultation tailored to the needs of individual projects 2. **The Topical Evaluation Networks**—provide a forum for ongoing dialog via electronic conferencing 3. **The Toolkit Program**—provides evaluators with tested methodologies and instruments related to specific topics 4. **The Materials Program**—an evaluation materials program that supplies evaluators with original papers on selected topics and identifies relevant literature in the field 5. **The Mini-Grant Program**—provides seed grants for significant evaluations in the area of adult mental health systems change 6. **The Training Program**—designed to enhance the evaluation skills of producers and consumers of evaluations.	SAMHSA, Center for Mental Health Services Authors: Kim T. Mueser, Robert E. Drake, Robin E .Clark, Gregory J. McHugo, Carolyn Mercer-McFadden, and Theiman H. Ackerson	Yes	

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Training	Product Description	Source	Public Domain	Private Domain
Co-Occurring Disorders Treatment Manual	Newly developed training manual and participant workbook for training clinicians in group work with offenders who have co-occurring disorders. Currently being field-tested.	Suncoast Practice and Research Collaborative University of South Florida Florida Mental Health Institute 13330 Bruce B. Downs Boulevard Tampa, FL Roger H. Peters, Ph.D. Department of Mental Health Law and Policy phone: 813-974-1923 fax: 813-974-9327	Yes	
Mental Illness, Drug Addiction and Alcoholism, MIDAA(R), MICA	A guide to program implementation for dual/multiple disorders. Its forms, clinical tools, and staff development criteria provide a foundation for program development and treatment interventions in the substance abuse and mental health treatment settings.	Authored by Kathleen Sciacca, M.A. 299 Riverside Drive, 3E New York, NY 10025 Manuals are $65 each, plus shipping		Yes
MIDAA Service Manual: A Step by Step Guide to Integrated Treatment, Program Development and Services for Dual Diagnosis	see above			
Phase I Dual Diagnosis Group Treatment Manual	Multiple training manuals for Florida's Department of Corrections personnel who work with offenders diagnosed with co-occurring disorders.	Authored by Roger H. Peters, Ph.D., and Holly Hills, Ph.D. University of South Florida Florida Mental Health Institute Florida Department of Corrections Bureau of Substance Abuse Program Services Tallahassee, FL Pam Denmark, *Bureau Chief* (850) 410-4430	Yes	

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Training	Product Description	Source	Public Domain	Private Domain
Dual Disorders Recovery Counseling	Online publication that is not truly a training manual but can be used as such.	NIDA *Approaches to Drug Abuse Counseling* Authored by Dennis C. Daley, M.S.W. Assistant Professor of Psychiatry and Program Director Center for Psychiatric and Chemical Dependency Services University of Pittsburgh Medical Center Western Psychiatric Institute and Clinic 3811 O'Hara Street Pittsburgh, PA 15213 **http://165.112.78.61/ADAC/ADAC3.html**	Yes	
Core Training Courses for Management of MISA Treatment and Accommodation Programs	I. MISA: Integrated Concepts and Approaches—Minkoff's parallels are presented along with a review of the complexities that multiple disorders may present for engagement, diagnosis, treatment, and recovery. II. MISA: Treatment and Supports—Includes individualized approaches to developing treatment strategies and related levels of support, as well as the role of case management in providing the continuity, linkage, and supports needed to facilitate recovery. III. MISA Recovery, Rehabilitation, and Self Help: What, When, and How—This seminar focuses on the internal process of recovery, stages, and possible supports needed. It also includes the types of structures and uses of psychiatric rehabilitation in facilitating recovery and providing needed skills and alternative coping strategies.	PA MISA RFP Required Training —Pennsylvania		

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Training	Product Description	Source	Public Domain	Private Domain
	IV. MISA Crisis and Relapse Intervention—Review of: • The cycle of crisis vulnerability, crisis state, and resolution • Preventing a crisis—creating situations • Designing interventions for lowering arousal • Creating opportunity for teaching new coping skills in the direct aftermath of a crisis.			
	V. MISA Groups and Groups Skills— Reviews principles and skills needed to develop specific kinds of modalities and group goals, norms, and processes. Psychoeducational and skills-based groups are a major focus.			
	VI. MISA and Psychopharmacology: An Overview—Part 1 reviews basic classes of psychoactive medications, potential major side effects, and interactions. Part 2 reviews street drugs and alcohol and their effects.			
	VII. MISA: Working Respectfully with Family Members and Significant Others—This seminar examines the centrality and impact of families of origin and other constructed "families."			
	VIII. Ethics and Boundaries for Effective MISA Practice —This course addresses basic ethical principles on which all human-service endeavors are based.			
	IX. MISA Treatment Planning and Documentation Issues —Principles of collaborative treatment planning.			
	X. MISA Practice Principles for Continuous Quality Improvement and Collaboration—Principles for incorporating the attitudes and skills needed for effective practice, working in collaboration with others, and incorporating an outcomes-based focus.			

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Training	Product Description	Source	Public Domain	Private Domain
	XI. Principles of Engagement: Children and Adolescents with Co-Occurring Disorders and Their Families—Explores interpersonal dynamics that facilitate interaction between therapist, client, and families and that affect the process of recovery.			
Principles for the Care and Treatment of Individuals with Co-Occurring Psychiatric and Substance Abuse Disorders as They Apply to Individuals with Serious and Persistent Mental Illness (SPMI), October 1998	The Continuous, Comprehensive, and Integrated System of Care (CCISC) model principles in this report apply to the broad population of people with co-occurring disorders. The principles are as follows: • Principle #1—Integration • Principle #2—Continuity • Principle #3—Comprehensiveness • Principle #4—Quality • Principle #5—Implementation.	Community Consensus-Building Collaborative: Community Action Grant for Exemplary Practice A project of the Massachusetts Department of Mental Health in Collaboration with the Department of Public Health, the Division of Medical Assistance, the Massachusetts Behavioral Health Partnership, consumers, family members, and providers		
Co-Occurring Psychiatric and Substance Abuse Disorders: Diagnosis and Treatment—Psycho-pharmacology Practice Guidelines (Minkoff et al., 1998) ***Arizona Integrated Treatment Consensus Panel: Training Modules***	Through a Phase I grant from SAMHSA, the Arizona Department of Health Services formed the AITCP in January 1999 to forward community consensus on implementing integrated treatment in Arizona. The AITCP included representatives of the substance abuse and mental health systems in Arizona, consumers, family members, service providers, and advocates. Phase II will continue to broaden the work of the Phase I Panel in key areas: (1) staff competencies and (2) support for the ongoing planning and implementation activities of the statewide steering committee and RBHA. Training Modules: This program aims to provide introductory training for staff new to clinical services. It is also for experienced clinical staff to use as a reference.	The Arizona Department of Health Services/Division of Behavioral Health Services	Yes	

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Training	Product Description	Source	Public Domain	Private Domain
	The training module should be used as a starting point for further study. The end of the module features a collection of journal articles and suggested readings.			
Co-Occurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies, and Training Curricula	This report is the result of the collective efforts of a national panel of dual diagnosis experts between October 1996 and February 1998. The panel met to develop national standards, workforce competencies, and training curricula for the treatment of people with co-occurring disorders in managed care systems. The panel members were selected to represent consumers, family members, and providers. They also represented people with geographic, cultural, and racial diversity as well as people from public-sector, private-sector, psychiatric, and substance abuse disorder backgrounds.	Report of the Center for Mental Health Services Managed Care Initiative: Clinical Standards and Workforce Competencies Project Co-Occurring Mental and Substance Disorders (Dual Diagnosis) Panel January 1998	Yes	
Curriculum for MICAA and CAMI Direct Care Providers: Mental Illness, Drug Addiction and Alcoholism MIDAA®: Training, Cross Training, and Program Development				
A Collaborative Response: Addressing the Needs of Consumers with Co-Occurring Substance Use and Mental Disorders—Participant Guide ***Also includes a CD-ROM***	Addresses the common issues and struggles professionals describe when working with these special needs consumers. The peer-led cross-training is designed for supervisors and practitioners alike. Participants are not required to have any special expertise—each is an equal partner in the learning experience. Participants meet in small groups of 5 to 10 people who bring different life experiences and insights. Each small group has a resource leader(s). Controversial topics stimulate open and honest communication and provide opportunities for new discoveries.	Mid-America Addiction Technology Transfer Center Kansas City, Missouri **www.mattc.org**	Yes	

Training	Product Description	Source	Public Domain	Private Domain
VHS on Drug Abuse and the Brain from the NCADI Video Resource Program ***Psychotherapeutic Medications 2001: What Every Counselor Should Know*** ***Cultural Issues in Substance Abuse Treatment*** ***Coordination of Alcohol, Drug Abuse, and Mental Health Services*** ***Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse: Treatment Improvement Protocol (TIP) Series***	The training builds a collaborative response among multidisciplinary professionals. Opportunities for interdisciplinary, small-group interaction enable participants to apply new information, identify agency or program internal resources, explore community resources, and provide feedback to leadership regarding improved service for people with co-occurring disorders. A second and equally important goal encourages participants to provide feedback to leadership regarding existing or potential barriers and opportunities in existing agency/programming. There is an evaluation form at the conclusion of each module.			
Assessment of Substance Related and Mental Health Disorders	This master's level course is available for credit on line through the University of Iowa. A paper-and-pencil version is also available. Instructors who want to replicate the course can obtain a syllabus.	Prairielands ATTC 319-335-5368 **http://www.uiowa.edu/~attc**	Yes	

Training	Product Description	Source	Public Domain	Private Domain
Behavior Shaping/ Management in the Therapeutic Community Setting	A curriculum package addressing theory, tools, and skills in changing behavior for residential and nonresidential TC environments. This course can be applied to community treatment environments as well as correctional-, mental health-, adolescent-, and women with children-focused programs. Length equals 36 hours—includes lecture and learning activities.	Pacific Southwest ATTC 858-551-2944 **http://www.attc.ucsd.edu**	Yes	
Dual Diagnosis and the DSM-IV Categories	Review of diagnostic criteria related to substance abuse and addiction. Compares diagnostic categories for mental and substance abuse disorders. Also provides an introduction to assessment skills and tools.	Pacific Southwest ATTC 858-551-2944 **http://www.attc.ucsd.edu**	Yes	
Mental Health Specialist Training Course—Prevention of Alcohol, Tobacco, and Other Drug Problems	This 1-day course for mental health specialists provides increased understanding of MHS roles and attitudes toward alcohol, tobacco, and other drugs (ATOD), knowledge about prevention of ATOD problems, and the skills to detect and appropriately refer clients with ATOD problems. Key objectives of the course are to: • Establish a learning community environment • Clarify the mental health specialist's role in the prevention of ATOD • Describe the history and development of the prevention approach • Define prevention • Provide information on addiction • Demonstrate effective communication skills when discussing primary prevention and early identification strategies • Develop an action plan. The complete curriculum package is available in print form.	New England ATTC 401-444-1808 **http://www.caas.brown.edu/ATTC-NE**	Yes	

Training	Product Description	Source	Public Domain	Private Domain
Treating Alcohol and Other Drug Clients Multi-diagnosed with Traumatic Brain Injury and/or Mental Health Diagnosis	A training manual/curriculum for substance abuse counselors or those training to become substance abuse counselors. The program aims to educate participants on how substance use and abuse affect the outcome of traumatic brain injury (TBI), skills for functionally assessing individuals with alcohol and other drug issues and TBI or mental diagnosis, and procedures for intervention and client engagement with this population.	Northeastern States ATTC 518-442-5702 **http://www.albany.edu/pdp/attc** Hard copy–$25, diskette–$5	Yes	
An Eco-Systemic Addiction and Mental Health Treatment Model: A Training Module	A training module that presents an ecological treatment model for multidiagnosed patients/consumers (and their families) who present with complex medical, addictive, psychiatric, and psychosocial problems. This innovative treatment approach bridges core medical, psychiatric, social work, nursing, and recovery principals as well as beliefs, practice realities, and strategies. The curriculum includes handouts, worksheets, overheads, outlines, and a training manual.	Northeastern States ATTC 518-442-5702 **http://www.albany.edu/pdp/attc** Hard copy–$20, diskette–$5	Yes	
Substance Abuse Treatment for People with Severe Mental Disorders: A Program Manager's Guide	Though not a true training curriculum, this book provides guidance to leaders of mental health, substance abuse treatment, and behavioral health systems. The book details guidelines for planning and managing dual disorders programs. It includes a 33-page Executive Summary and a 219-page detailed text with exhibits and appendices. Prepared for the Community Support Program. Contains chapters addressing: • Review of the Literature • Treatment Principles • Organizing Dual Disorders Services	*New Hampshire-Dartmouth Psychiatric Research Center* $29.95 Authors: Carolyn Mercer-McFadden, Robert E. Drake, Robin E. Clark, Nicholas Verven, Douglas L. Noordsy, and Thomas S. Fox Order from: Karen Dunn New Hampshire-Dartmouth PRC 2 Whipple Place, Suite 202 Lebanon, NH 03766 603-448-0126		Yes

Training	Product Description	Source	Public Domain	Private Domain
	• Leadership and Implementation • Cost and Financing Issues • Clinical Controversies			
Louisiana Integrated Treatment Services Curriculum	The curriculum is presented in thirteen 3-hour workshops or as a 15-week graduate-level psychology course at McNeese State University. It is intended for treatment professionals in addictions or mental health and usually presented to both groups at the same time. Preinstruction and postinstruction evaluations show high levels of satisfaction with the training, along with shifts in knowledge and attitudes consistent with training objectives. The curriculum content includes: • Overview of Louisiana Integrated Treatment Services Model • Characteristics of Substance and Mental Disorders • Characteristics of Co-Occurring Disorder Population • Special Populations • Family Needs/Contributions • Behavioral Pharmacology—basic principles • Behavioral Pharmacology—implications for treatment • Screening and Assessment • Motivational Interviewing • Group Intervention • Functional Analysis/Treatment Planning Relapse Prevention • Community Reinforcement and Family Therapy (CRAFT)/Case Management.	For information contact: Cam L. Melville, Ph.D. Professor Department of Psychology McNeese State University Lake Charles, LA 70609 (337) 475-5462 **melville@mail.mcneese.edu** Cost is $600 per workshop.		Yes

Training	Product Description	Source	Public Domain	Private Domain
The Basics: A Curriculum for Mental and Substance Use Disorders, Second Edition	This curriculum will be available in January 2002. It is a two-volume set (600 pages each) and includes: • Cross-training for mental health and substance abuse practitioners • Full instructions to trainers and content material • Worksheets/handout masters. The curriculum can be used with practitioners and clients. The author is available to provide training for use of the curriculum.	Rhoda McKillup, Author Spokane, WA 509-258-7314 Cost: $100 for the 2 volumes		Yes
Co-Occurring Disorders Service Enhancement Toolkit	This train-the-trainer curriculum has several components. Toolkit #2 is for clinical competencies, Toolkit #3 comprises case vignettes, and Toolkit #5 is for program self-assessment. A Web site for the materials is currently under construction.	Zialogic 6501 Wyoming Boulevard, N.E., Suite 205 Albuquerque, NM 87111 505-823-6687 **cac@swcp.com** Costs vary depending on the entity or person requesting the materials (i.e., nonprofit agency vs. State agency).		Yes
Potential Sources of Future Training Curricula—CMHS Community Action Grant Recipients	The SAMHSA Center for Mental Health Services funds Community Action Grants that support communities to adopt specific exemplary practices into their systems of care for adults with serious mental illness and children with serious emotional disturbances. These grants encourage communities to convene partners, build consensus, eliminate barriers, support decisions, and adapt service models to meet local needs. Some grantees have chosen to focus on co-occurring disorders.	Potential sources are grantees in Oklahoma, Florida, Maryland, Maine, and Rhode Island	Yes	

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